PREMIER ACCESS (PPO) PLAN

BENEFIT	COST SHARING	
	IN-NETWORK	OUT-OF-NETWORK
Deductible	Single $400 / $1000 / $1500 Family $800 / $2000 / $3000	Single $700/$1500/$2250 Family $1400/$3000/$4500
Maximum out of Pocket for Covered Expenses After Deductible	Single $1500 / $2500 / $4000 Family $3000 / $5000 / $8000	Single $2500/$4000/$5000 Family $5000/$8000/$10000
Coinsurance	As Indicated	As Indicated
Lifetime Maximum Benefit	Unlimited for $400/$800 deductible $2 million for all other deductibles in-network and out-of-network benefits	Unlimited for $700/$1400 deductible $2 million for all other deductibles in-network and out-of-network benefits
In-Hospital Care - Authorized Semi Private Room and Misc. Services, Intensive/Cardiac/Neonatal	15% Coinsurance Amount - No Deductible	35% Coinsurance Amount*
Ambulatory/Hospital Outpatient Surgery	20% Coinsurance Amount*	40% Coinsurance Amount*
Transplant (Kidney, Cornea, Bone Marrow, Heart, Liver, Lung, Heart/Lung, Pancreas), Small Bowel)	15% Coinsurance Amount - No Deductible	35% Coinsurance Amount*
Out-Patient Services - Provider Office Visit, Diagnostic & Allergy Testing, Allergy Serum and Injections, Diabetes Education and Therapy, Radiation, Chemotherapy, and Dialysis	$10 Co-payment (includes all services provided during the office visit) 20% Coinsurance Amount for services not provided during the office visit*	40% Coinsurance Amount*
Maternity Care - Prenatal, Labor, Delivery and Postpartum (Pregnancy of Dependents Covered)	$10 Co-payment for Office Visit in Which Pregnancy is Diagnosed 15% Coinsurance Amount for Hospitalization*	35% Coinsurance Amount*
Emergency Services - Hospital Emergency Room (Coinsurance Waived if Admitted)	20% Coinsurance Amount*	20% Coinsurance Amount*
Ground Only Ambulance	20% Coinsurance Amount*	20% Coinsurance Amount*
Preventive Services:		
Immunizations	Included in Office Visit Co-payment	Preventive Services Are Not Covered Out of Network
Well Child Care - Age and Periodicity Limits May Apply	Per Plan Year Ages 0-3 Office Visits Covered to $200 - Ages 4-18 Office Visits Covered to $100 - No Coverage Above Limit $10 Co-payment	
Well Adult Care - Age and Periodicity Limits May Apply	Per Plan Year $300 for Routine Physical Exam and Specified Testing No Coverage Above Limit $10 Co-payment	
Mental Health:		
Inpatient	20% Coinsurance Amount, 21 days/plan year, 1 admission/6 months* (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis)*	40% Coinsurance Amount, 21 days/plan year, 1 admission/6 month* (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis)
Outpatient	20% Coinsurance Amount, 20 visits per plan year*	40% Coinsurance Amount, 20 visits per plan year*
Autism - $500 Monthly Benefit for Children Ages 2 through 21 Years of Age for Therapeutic, Respite and Rehabilitative Care	Coinsurance Applicable to Service Provided*	Coinsurance Applicable to Service Provided*
Substance Abuse:		
Inpatient	20% Coinsurance Amount, 21 days/plan year, 1 admission/6 months* (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis)*	40% Coinsurance Amount, 21 days/plan year, 1 admission/6 months* (Day Treatment/Intensive Outpatient Can be Substituted for Inpatient Days on a 2 for 1 Basis)*
Outpatient	20% Coinsurance Amount*, 20 visits per plan year	40% Coinsurance Amount*, 20 visits per plan year

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	IN-NETWORK	OUT-OF-NETWORK
Prescription Drugs, including Oral Contraceptives	20% Coinsurance Amount* - 1 month supply unless mail order available*	40% Coinsurance Amount* - 1 month supply unless mail order available*
Physical/Occupational/Cardiac Rehabilitation Therapy	20% Coinsurance Amount* 26 Weeks/Plan Year	40% Coinsurance Amount* 26 Weeks/Plan Year
Speech Therapy	20% Coinsurance Amount* 26 Weeks/Plan Year	40% Coinsurance Amount* 26 Weeks/Plan Year
Home Health Care	100 Visits Per Plan Year Covered in Full*	100 Visits Per Plan Year - 20% Coinsurance Amount*
Skilled Nursing Facility	20% Coinsurance Amount* 28 Days/Plan Year	40% Coinsurance Amount* 28 Days/Plan Year
DME/Prosthetics/Hearing Aids	20% Coinsurance Amount*	40% Coinsurance Amount*
Hospice	Medicare Benefit*	Medicare Benefit - 20% Coinsurance*

*Deductible Applies. The single and family deductible amounts may be either:

- A combined deductible for both medical and pharmacy services; or
- A split deductible with a set amount for medical services and for pharmacy services.

- PPO out-of-network coverage is limited to usual, reasonable and customary charges.
- PPO out-of-network coverage for preventive services is not available.
- PPO out-of-network coverage for transplants, substance abuse and mental health services is subject to certification.
- PPO in-network coverage for maternity care – the initial office visit in which pregnancy is diagnosed is subject to the provider office visit copayment. No additional copayments are applied to prenatal visits. All other in-network maternity expenses are subject to the deductible and coinsurance except as noted in the following comment.
- PPO in-network deductible does not apply to hospitalization.